

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/08/2014
NAME OF PROVIDER OR SUPPLIER HAMILTON PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 7 and 8, 2014</p> <p>Facility number: 004686 Provider number: N/A AIM number: N/A</p> <p>Survey team: Virginia Terveer, RN, TC Sue Brooker, RD Julie Call, RN Martha Saull, RN</p> <p>Census bed type: Residential: 12 Total: 12</p> <p>Census payor type: Private: 12 Total: 12</p> <p>Sample: 7</p> <p>Hamilton Place was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 05/09/14 by Lisa McColly</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE